

This compares most favorably with verapamil, which has a similar reported conversion rate (greater than 80%) but a higher incidence of hypotension and cardiac depression.

Like verapamil, diltiazem is recommended for stable patients with narrow-complex supraventricular tachycardia as well as for the temporary control of rapid ventricular rate in atrial fibrillation or atrial flutter. The use of diltiazem, like that of verapamil, is contraindicated in patients with wide-complex tachycardia, sinoatrial or atrioventricular nodal disease, and recent β -blocker usage. The current recommended dose is 0.25 mg per kg given slowly by intravenous pyelogram over one to two minutes. If no response and no episodes of hypotension are seen after 30 minutes, the dose should be repeated at 0.35 mg per kg. Intravenous diltiazem is proving to be safe, effective, and well tolerated by patients with supraventricular tachycardia. It may soon supplant verapamil in the treatment of refractory tachycardia.

THOMAS J. PEITZ, MD
San Diego, California

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Management of Combative Trauma Patients

THE EVALUATION IN AN EMERGENCY DEPARTMENT of an agitated, combative patient with major trauma can be difficult. It is important that physicians dealing with patients of this type have a systematic approach to their management. Combateness by injured patients may be due to hypoxia, hypovolemia, head injury, drug or ethanol ingestion, pain, or psychogenic causes. Identifying and correcting the problem requires a physical examination and diagnostic testing. This may be impossible in a combative patient, however, leaving a clinician with three options: physically restrain the patient and delay diagnostic evaluation until the patient calms down, use a sedating agent, or invoke total chemical restraint with paralysis and intubation.

Physical restraint and observation is an inappropriate approach to a possibly injured patient. Attributing combateness to intoxication or to psychogenic causes can be a fatal error in judgment.

Sedating agents used to control combative patients include narcotics, benzodiazepines, and butyrophenones. Narcotics and benzodiazepines have a rapid onset of action and are titratable and reversible. Respiratory depression and hypotension, however, are serious drawbacks with both classes of drugs. Butyrophenones (haloperidol and droperidol) have been suggested as the optimal sedating agents for the control of combative trauma patients. Both agents cause sedation with little effect on the respiratory drive. Possible complications of their use include prolonged sedation, hypotension, dystonic reactions, a

neuroleptic malignant syndrome, and adverse interactions with ethanol or street drugs.

Total chemical restraint of a combative trauma patient with paralysis and ventilatory support has been called "inhumane" and "not justifiable." Some condemnation of this practice is based on the fear of iatrogenic complications, most important the possibility of paralyzing a patient and then being unable to ventilate that patient. Other possible complications of neuromuscular blockade include aspiration, hyperkalemia, and malignant hyperthermia. These complications, however, are rare; the risks must be weighed against the benefits of truly adequate airway control and expediting the diagnosis and management of serious injuries.

The management of combative trauma patients must be individualized. Hemodynamically stable combative patients with a low probability of major head injury can be managed with sedation alone using butyrophenones as the agents of choice. Combative patients with signs of a serious head injury should be managed from the start with rapid-sequence paralysis and intubation. Hemodynamically unstable patients should undergo rapid evaluation and resuscitation, and if it appears risky to sedate such patients without controlling their airway, neuromuscular blockade and sedation should be considered.

MONICA ROSENTHAL, MD
Oakland, California

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Improving Emergency Department Response to Victims of Domestic Violence

MANY WOMEN who seek care in emergency departments are estimated to have symptoms directly or indirectly related to domestic violence. Some will present with injuries due to battering. Many others present with non-traumatic symptoms, such as depression, suicide attempts, chronic pain syndromes, hyperventilation, and sleep disorders. Some of the 15% to 25% of pregnant women who are battered will have pregnancy-related symptoms, such as pelvic pain, vaginal bleeding, or impending miscarriage.

Despite the prevalence of domestic violence, the diagnosis is frequently missed. Some reasons are cited in the literature for this failure to diagnose, including time constraints, failure of a patient to volunteer information, and the lack of training, prejudice, and misunderstanding on the part of medical personnel.

Although there may be clues that suggest domestic violence, from a patient's inappropriately flat or fearful demeanor, a central or defensive pattern of injuries, or the